Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

RICHARD FALLON, M.D.,

Petitioner,

v.

STATE BOARD OF REGISTRATION
FOR THE HEALING ARTS,

Respondent.

On Petition For A Writ Of Certiorari To The Supreme Court Of Missouri

PETITION FOR A WRIT OF CERTIORARI

RICHARD J. PAUTLER
LEWIS R. MILLS
THOMPSON COBURN LLP
One Firstar Plaza
St. Louis, MO 63101
(314) 552-6470

MIGUEL A. ESTRADA
Counsel of Record
THOMAS G. HUNGAR
ANDREW S. TULUMELLO
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

Counsel for Petitioner

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), preempts a state medical board from subjecting the medical director of a managed care organization to a disciplinary process because the medical director allegedly made an improper benefits determination in the course of administering an ERISA plan.

PARTIES TO THE PROCEEDINGS

All of the parties to the proceedings in the court below are included in the caption on the cover page of this petition. Petitioner Richard Fallon was formerly employed by Prudential Health Care, Inc., which in 1999 was acquired by Aetna, Inc., a publicly-traded company.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Richard Fallon respectfully petitions this Court for a writ of certiorari to review the judgment of the Supreme Court of Missouri in this case.

OPINIONS BELOW

The opinion of the Supreme Court of Missouri (Pet. App. 1a-7a) is reported at 41 S.W.3d 474 (Mo. 2001). The order of the Circuit Court of Cole County granting the Board's application to enforce its subpoena to Dr. Fallon (Pet. App. 8a-12a) is unreported.

JURISDICTION

The judgment of the Supreme Court of Missouri was entered on April 10, 2001. On July 6, 2001, Justice Stevens extended the time within which to file a petition for certiorari to and including August 8, 2001. *See* Application No. 00A1148. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a). *See Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469, 482-83 (1975).[1]

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[1] The judgment of the Supreme Court of Missouri satisfies the four requirements for immediate review under *Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469 (1975): (1) the federal question, concerning ERISA preemption, has been finally decided; (2) petitioner might prevail on remand on nonfederal grounds, making review of the federal issue unnecessary; (3) reversal of the state court judgment on preemption grounds would preclude further litigation; and (4) denying immediate review might seriously erode federal policy regarding the scope of ERISA preemption of state laws that purport to authorize alternative remedies to ERISA's exclusive civil enforcement scheme. *See id.* at 482-83.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the Constitution, U.S. Const., art VI, cl. 2, and the pertinent provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), are set forth at Pet. App. 25a-26a.

STATEMENT OF THE CASE

1. Petitioner Richard Fallon is a physician licensed in the State of Missouri. From November 1988 to December 1999, Dr. Fallon served as the Medical Director for Prudential Health Care ("Prudential"). Pet. App. 9a. Until 1999, Prudential was a managed care company that contracted with employers and others to administer benefits available under plans established pursuant to the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.*, ("ERISA"). In 1999, Prudential's health business was acquired by Aetna, Inc.

As Medical Director for Prudential's health plans, Dr. Fallon was responsible for determining whether treatment proposed for (or rendered to) a Prudential plan participant was covered under that member's plan. That process—known as "utilization review"—required Dr. Fallon and his staff to make only *coverage* determinations. *See* Pet. App. 10a-12a. In many cases, the health plans administered by Prudential provided coverage only for treatment that was "needed and appropriately provided" or "medically necessary"—contractual terms that were defined in each member's plan. *See* Pet. App. 4a-6a, 9a. Neither Dr. Fallon nor Prudential's utilization review personnel treated or otherwise provided medical care to any Prudential plan participants. *See* Pet. App. 4a, 11a.

In late December 1998, Dr. Fallon reviewed a request to "precertify" coverage for surgery and various reconstructive orthodontia work for V.G., a participant

in a plan administered by Prudential, to alleviate what V.G.'s physicians had diagnosed as temporomandibular joint dysfunction (TMJ). *See* Pet. App. 2a, 10a. On January 19, 1999, after reviewing the materials submitted by V.G.'s physicians and consulting with Prudential's oral surgery consultant, Dr. Fallon denied pre-certification for all proposed services. *See* Pet. App. 10a-11a. Dr. Fallon concluded that the proposed surgery was not "medically necessary" as that phrase was used in V.G.'s health plan and that the proposed reconstructive work was "dental in nature" and within her plan's exclusion for "dental" services. *See id.*

On January 27, 1999, V.G.'s oral surgeon filed a complaint against Dr. Fallon with respondent, the Missouri State Board of Registration for the Healing Arts ("Board"). *See* Pet. App. 2a. Established in 1949 "for the purpose of registering, licensing and supervising all physicians and surgeons" in the state, *see* Mo. Stat. § 334.120.1, the Board is authorized to investigate allegations that a physician engaged in "conduct . . . [that] is or might be harmful or dangerous to the mental or physical health of a patient or the public." Mo. Stat. § 334.100.2(4)-(5). If it determines that disciplinary action against a physician is warranted, the Board may file a complaint with an administrative hearing commission, which will conduct an evidentiary hearing and issue findings of fact and conclusions of law that are subject to judicial review, *see* Mo. Stat. §§ 621.105, 621.145, or, in cases that present a "substantial probability of serious danger to the health, safety or welfare" of Missouri residents, it may file for emergency injunctive relief in a Circuit Court of general jurisdiction. *See* Mo. Stat. § 334.230(2). The Board's enforcement powers include censure, reprimand, and suspension or revocation of the physician's medical license. *See* Mo. Stat. § 334.100.3. The Board is empowered to subpoena witnesses and documents in the

discharge of those investigative powers. *See* Mo. Stat. § 334.127.

On November 23, 1999, the Board issued a "Notice And Subpoena Duces Tecum" to Dr. Fallon. *See* Pet. App. 2a. The subpoena provides notice that the Board is investigating Dr. Fallon's "denial of surgical insurance coverage on patient [V.G.]" and commands Dr. Fallon to appear before the Board "for a taped, investigative interview, which will be conducted under oath." Pet. App. 23a. The subpoena further directs Dr. Fallon to "bring any and all patient records . . . , documents, reports, and/or other written memorializations regarding your *denial of surgical insurance coverage*" to the interview. *Id.* (emphasis added). Dr. Fallon was instructed to appear at the Board's office in Jefferson City, Missouri on December 8, 1999. *See* Pet. App. 23a-24a.

Dr. Fallon did not appear before the Board as directed by the subpoena. Pursuant to Missouri Stat. § 334.127, the Board then applied to the Circuit Court of Cole County for an order to compel his appearance.[2] *See* Pet. App. 2a. On January 31, 2000, the Circuit Court issued an order directing Dr. Fallon to show cause for his failure to comply with the subpoena. In response, Dr. Fallon asserted that the Board's subpoena

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[2] Section 334.127.2 of the Missouri Code provides:

> The board may enforce its subpoenas, including subpoena duces tecum, by applying to a circuit court of Cole County, the county of the investigation, hearing or proceeding, or any county where the person resides or may be found, for an order upon any person who shall fail to obey a subpoena to show cause why such subpoena should not be enforced.

Mo. Stat. § 334.127.2.

was unenforceable because it "relate[d] to" a denial of benefits under an ERISA plan—in particular, to the "denial of surgical insurance coverage" to V.G.—and was thus preempted by ERISA. *See* Pet. App. 2a-5a, 13a-21a, 22a. Dr. Fallon also contended that the Board lacked authority to subpoena him because Prudential was a "utilization review agent" as defined by section 374.500(6) of the Missouri Code and therefore subject to the exclusive jurisdiction of the Missouri Department of Insurance. *See* Pet. App. 6a-8a.[3]

2. On April 4, 2000, the Circuit Court entered an order enforcing the subpoena duces tecum against Dr. Fallon. The Circuit Court found that "Dr. Fallon performs . . . 'utilization review' . . . as a part of . . . [ERISA] plan administration;" that Dr. Fallon's "sole and exclusive involvement in [V.G.'s] care was making a determination of whether or not benefits would be

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[3] Section 374.500 provides in relevant part:

> As used in sections 374.500 to 374.515 [of Chapter 374 of the Missouri Code], the following terms mean:
> ***
> (5) "Utilization review," a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review . . .
> (6) "Utilization review agent," any person or entity performing utilization review.

Mo. Stat. § 374.500. The Department of Insurance is vested with exclusive jurisdiction to regulate the provision of utilization review services in the State of Missouri. *See* Mo. Stat. § 374.100.

available for . . . TMJ surgery under the plan;" that Dr. Fallon never saw or spoke to, let alone examined, prescribed treatment, or "counseled against any form of treatment for" V.G.; and that Dr. Fallon "never attempted or purported to assume responsibility for [V.G.'s] medical care or treatment." Pet. App. 10a-11a. Nonetheless, the Circuit Court concluded that because Dr. Fallon had evaluated whether the treatment proposed for V.G. was "medically necessary"—a determination that required the exercise of medical judgment—the Board was not barred from "reviewing Fallon's utilization review actions as Medical Director." *See id.*

3. The Supreme Court of Missouri affirmed.[4] *See* Pet. App. 2a-5a. In a unanimous opinion, the Court held that the statute authorizing the Board's action—section 334.127—did not "relate[] to" an ERISA plan within the meaning of section 514(a) of ERISA because the statute neither made "reference" to nor had a "connection" with any employee benefit plan. *Id.* In particular, the Court concluded that "the determinations [made by Dr. Fallon] fall outside the scope of plan administration" because "[Dr. Fallon] used medical training and judgment to make a decision about the 'medical necessity' of surgical treatment for a particular patient." Pet. App. 4a. The Court reasoned that Dr. Fallon's "purely medical decision" was "analytically distinct" from plan administration:

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[4] The Supreme Court of Missouri has exclusive jurisdiction over appeals that involve challenges to the validity of state statutes. *See* Miss. Const. Art. V. § 3 ("The supreme court shall have exclusive appellate jurisdiction in all cases involving the validity of a treaty or statute of the United States, or of a statute or provision of the constitution of this state . . .").

> [Although] Prudential made an *administrative* decision when it determined that the plan would not extend benefits to cover [treatment] unless the medical director found it to be "needed and appropriately provided[,]" . . . Dr. Fallon . . . made a purely *medical* decision when he determined that the procedure was "not medically necessary."

Pet. App. 6a (emphasis in original). The Court concluded that although "ERISA may pre-empt state laws that interfere with *coverage decisions*, it does *not* prevent the state from exercising its traditional police powers to review the *medical judgments* of one of its licensed physicians." Pet. App. 5a (emphasis added). The Court also rejected Dr. Fallon's state-law grounds of appeal. *See* Pet. App. 5a-7a.

REASONS FOR GRANTING THE WRIT

The decision below cannot be reconciled with the consistent course of this Court's decisions construing ERISA, all of which make clear that ERISA preempts any state attempt to provide mechanisms for second-guessing the benefit determinations of plan administrators. Those benefit determinations, this Court's cases teach, may be challenged only under the provisions of ERISA § 502, 29 U.S.C. § 1132. *See, e.g.*, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). Not surprisingly, the decision below conflicts with the overwhelming weight of authority in the lower federal courts, including the federal courts sitting in Missouri, which have faithfully followed the guidance set forth by this Court in *Pilot Life* and its progeny. *See, e.g.*, *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999), *cert denied,* 528 U.S. 1189 (2000) (involving a plan beneficiary's suit against petitioner); *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321

(5th Cir. 1992). The decision of the Supreme Court of Missouri—which authorizes a state medical board to discipline a plan administrator for making an adverse benefits determination—squarely conflicts with those cases.

I. The Decision Below Conflicts With This Court's Cases.

1. Section 514(a) of ERISA preempts State laws "insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Although this Court has cautioned that "the term 'relate to' cannot be taken 'to extend to the furthest stretch of indeterminacy,' or else 'for all practical purposes pre-emption would never run its course,'" *Egelhoff v. Egelhoff*, 121 S. Ct. 1322, 1327 (2001) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995)), this Court's cases make clear that state laws unquestionably are preempted to the extent they purport to authorize "alternative enforcement mechanisms" (*Travelers*, 514 U.S. at 658) to the remedial provisions set forth in Section 502 of ERISA, 29 U.S.C. § 1132.

That principle was established in this Court's unanimous decision in *Pilot Life*, which held that state-law contract and tort claims filed against an insurer for the "bad faith" denial of certain disability benefits under an ERISA plan were preempted by section 514(a). *Pilot Life*, 481 U.S. at 55. Although the tort of "bad faith" had long been used to seek damages for wrongful benefits denials, the Court concluded that permitting such a cause of action would amount to giving plan beneficiaries an alternative enforcement mechanism for contesting the denial of ERISA benefits. *Id.* at 54, 57. As the Court explained, any state-law cause of action that amounts to such an alternative enforcement action is preempted by ERISA, because Congress clearly

intended for the remedies set forth in ERISA § 502(a), 29 U.S.C. § 1132(a), to be exclusive:

> The six carefully integrated civil enforcement provisions found in § 502(a) of the statute . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.

Pilot Life, 481 U.S. at 54 (emphasis in original). The Court emphasized that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants were free to obtain remedies under state law that Congress rejected in ERISA." *Id.*

On the same day it decided *Pilot Life*, this Court held that the preemptive effect of ERISA's civil enforcement provisions is so strong and complete that an ERISA preemption defense under section 502(a) provides a sufficient basis to remove a state cause of action to a federal forum, notwithstanding the traditional limitation imposed by the well-pleaded complaint rule. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987). *Pilot Life* and *Taylor* thus make clear that respect for the exclusivity of ERISA's civil enforcement scheme is essential "to ensure that plans and plan sponsors [are] subject to a uniform body of benefits law," *Travelers*, 514 U.S. at 655, and that state laws that interfere with that enforcement scheme—and *especially* state laws that provide *alternatives* to it—are preempted by *both* section 514(a) and 502(a). *See Pilot Life*, 481 U.S. at 47; *see also Ingersoll-Rand*, 498 U.S. at 135 (holding, unanimously, that ERISA preempts a state common law claim that an employee was unlawfully discharged to prevent his attainment of plan benefits).

Like the state-law claims at issue in *Pilot Life*, the Board's disciplinary action against Dr. Fallon concededly is "based on [Dr. Fallon's] alleged improper

processing of a claim for benefits." *Pilot Life*, 481 U.S. at 48. As the subpoena to Dr. Fallon makes clear, the Board's investigation is *not* directed to any *treatment* decision rendered by Dr. Fallon, but rather to his "denial of *surgical insurance coverage* to patient [V.G.]." Pet. App. 23a-24a (emphasis added). The Board's disciplinary process against Dr. Fallon clearly constitutes an enforcement mechanism that goes beyond ERISA's "carefully integrated" civil enforcement provisions. *Pilot Life*, 481 U.S. at 54; *see also Ingersoll-Rand*, 498 U.S. at 144. The Board's investigation thus "relates to"—indeed, it is specifically *directed* at—the administration of an ERISA plan and is preempted under *Pilot Life*. *See* 29 U.S.C. § 1144(a); *see also Egelhoff*, 121 S. Ct. at 1328 (rules that "govern[] the payment of benefits [are] a central matter of plan administration").

2. In reaching the contrary conclusion, the Supreme Court of Missouri relied upon the "presumption against pre-emption in areas of traditional state regulation." *Egelhoff*, 121 S. Ct. at 1330. It observed that the "historic police powers of the State include the regulation of matters of health and public safety," Pet. App. 4a (quoting *De Buono v. NYSA-ILA Med. & Clinical Serv. Fund*, 520 U.S. 806, 814 (1997)), and that such '"historic police powers . . . [are] not to be superseded by [a] Federal Act unless that was the clear and manifest purpose of Congress.'" *Id.* (quoting *Travelers*, 514 U.S. at 655).

The Supreme Court of Missouri's reliance on the presumption against preemption in traditional areas of state regulation was misplaced, because that presumption plainly has no application here. As the lower court conceded in this case, the Board's attempt to commence disciplinary action against Dr. Fallon does *not* relate to the traditional domain of state regulation—*i.e.*, licensing and supervision over the physician-patient

relationship, *see* Mo. Stat. § 334.120.1—but instead to Dr. Fallon's "denial of surgical insurance coverage to patient [V.G.]." Pet. App. 23a-24a. Dr. Fallon never spoke to or examined, much less treated V.G. for any medical condition. *See* Pet. App. 11a. That Dr. Fallon may have employed medical criteria in reviewing V.G.'s claim for benefits flows from the fact that such criteria govern the availability of coverage under the terms of V.G.'s contract; it does not alter the fact that Dr. Fallon's duties consisted *solely* of making a *coverage* determination in the course of administering an ERISA-governed plan. *See Pegram v. Herdrich*, 530 U.S. 211, 219 (2000) (noting that HMOs "commonly require utilization review . . . and approval in advance (precertification) for many types of care, keyed to standards of medical necessity or the reasonableness of the proposed treatment"). Indeed, the Circuit Court expressly found that Dr. Fallon's "sole and exclusive involvement in [V.G.'s] care was making a determination of whether or not *benefits* would be available for . . . TMJ surgery under the plan." Pet. App. 11a (emphasis added). In these circumstances, the presumption against preemption of state laws regulating "health and safety" can scarcely be invoked to defend the Board's action.[5]

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[5] Moreover, any presumption that otherwise might counsel in favor of upholding state laws in fields traditionally regulated by the States will be "overcome where . . . Congress has made its desire for pre-emption [clear]," *Egelhoff*, 121 S. Ct. at 1330, as Congress did in ERISA. Given the clarity of Congress' preemptive intent, this Court has not hesitated to find that even state laws dealing with matters of traditional state regulation are preempted when they conflict with or relate to ERISA plans. *See, e.g., Egelhoff*, 121 S. Ct. at 1330; *Boggs v. Boggs*, 520 U.S. 833 (1997); *Pilot Life*, 481 U.S. at 55.

[footnote continued on next page]

II. The Decision Below Creates A Conflict With Several Courts Of Appeals Over Whether ERISA Preempts State Laws That Purport To Establish Enforcement Mechanisms Beyond Those Set Forth In ERISA.

The decision below is plainly inconsistent with this Court's precedents. Not surprisingly, the decision below also conflicts with decisions of several courts of appeals, which have uniformly concluded that state laws that establish "alternative review mechanisms" for the denial of ERISA benefits are preempted under *Pilot Life*. In particular, the Eighth Circuit has held—repeatedly—that ERISA preempts *any* state law insofar as it seeks to review or correct the denial of benefits under an ERISA plan, even where in denying benefits the plan administrator exercised "medical judgment." Thus, the decision below creates an unworkable

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[Footnote continued from previous page]

Indeed, it is far from clear from this Court's recent cases that a "presumption against preemption" has any substantial role in the interpretation of unambiguous federal statutes. *Compare Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 518 (1992) (applying the presumption to narrowly construe the express preemption provision of the Federal Cigarette Labeling and Advertising Act), *with Geier v. American Honda Motor Co., Inc.*, 529 U.S. 861, 872-74 (2000) (rejecting contention that proponents of preemption bear a "special burden" to show that Congress intended to preempt a state law that frustrates a federal regulatory scheme); *see also* Viet D. Dinh, *Reassessing the Law of Preemption*, 88 Geo. L. J. 2085, 2092 (2000) ("there should be no general systematic presumption against or in favor of preemption"); Caleb Nelson, *Preemption*, 86 Va. L. Rev. 225, 231-32 (2000) ("A general rule that express preemption clauses would be read 'narrowly,' so that they contradict the fewest potential state laws, is hard to square with the Supremacy Clause[.]").

division of authority between the state and federal courts sitting in Missouri.

1. The key Eighth Circuit case establishing that ERISA preempts alternative review mechanisms to Section 502 involves a state-law challenge to a utilization review determination made by none other than Dr. Fallon—the petitioner here. *See Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999). In *Hull*, Dr. Fallon was sued for medical malpractice in state court by a Prudential Health Plan member for allegedly making an improper determination that a thallium stress test was not "medically necessary" as defined by the plaintiff's health plan. 188 F.3d at 942-43. Dr. Fallon removed the case to federal court, where the district court deemed the suit preempted. The Eighth Circuit affirmed, holding that "although Hull's characterization of his claims sounds in medical malpractice, the essence of his claim rests on the denial of benefits," and therefore his suit "fall[s] squarely within the scope of section 502(a) [and is] completely preempted by ERISA." *Id.* at 943.

In an argument strikingly similar to that asserted by the Board throughout the proceedings below, Hull contended that his claims were not preempted because they related not to plan *administration*, but to Dr. Fallon's *medical judgment* in denying coverage for the treatment Hull's physicians had proposed. *See* 188 F.3d at 942-43. According to Hull, that medical judgment established "a doctor-patient relationship between himself and Dr. Fallon." *Id.* The Eighth Circuit emphatically rejected that assertion, stating that "*[p]lan administrators necessarily exercise medical judgment in determining benefits due under the plan*" and that "Dr. Fallon had *no* relationship with Hull other than as Plan administrator." *Id.* at 943 (emphasis added). Because permitting Hull's claims to proceed would "expose plan administrators to varying state causes of action for

claims within the scope of section 502(a)," and thus "pose an obstacle to the purposes and objectives of Congress," the Court—relying on *Pilot Life*—held Hull's claims preempted. *Id.*

Hull is hardly an anomaly in the Eighth Circuit: both before and after it was decided, the Eighth Circuit has invalidated state-law claims against medical directors and other utilization review personnel for making allegedly improper benefits determinations. In *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298 (8th Cir. 1993), the Court held that claims for tortious interference, medical malpractice, and breach of contract asserted against a plan administrator for refusing to precertify a certain surgical procedure were completely preempted by ERISA. Rejecting the Kuhls' contention that ERISA did *not* preempt their state-law claims because Lincoln National's conduct "went beyond mere administration of benefits" in that it effectively "undertook the treatment of Buddy Kuhl according to its own medical opinions," the court held that "the decision not to precertify payment relates directly to Lincoln National's administration of benefits" and that "[u]nder *Pilot Life* . . . the Kuhl's state law claims . . . 'relate to' the . . . plan and are preempted" by section 514(a). 999 F.2d at 303.

Similarly, in *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436, 440 (8th Cir. 1997), the Eighth Circuit held that ERISA preempted a state law breach of fiduciary duty claim arising from a plan administrator's refusal to authorize coverage for high-dose chemotherapy cancer treatment. Golden Rule declined to precertify Painter's treatment on the ground that it was experimental and not "medically necessary." *Id.* at 437. Citing *Pilot Life* and *Kuhl*, the court held that Painter's "state law claims for Golden Rule's alleged mishandling of [her] claim" were preempted by ERISA, because her suit constituted

"a claim for benefits . . . governed by . . . [section] 1132(a)(1)(B)." *Id.* at 439-40 (citing authorities).

Finally, in *Thompson v. Gencare Health Systems, Inc.*, 202 F.3d 1072 (8th Cir. 2000) (*per curiam*), the court held that ERISA preempted a state law medical malpractice claim brought against a plan administrator for failing to authorize coverage for certain cancer treatment. 202 F.3d at 1073. In so doing, the Eighth Circuit noted that the case presented "a recurring legal issue" in which "[t]he controlling principles are well-settled in this circuit." *Id.* Citing *Pilot Life*, *Kuhl*, and *Hull*, the Court held that "ERISA completely preempts a state law medical malpractice claim when the essence of [the] claim rests on the denial of benefits." *Id.* at 1073 (citation omitted).

The decision below plainly conflicts with those cases. In holding that Dr. Fallon's "medical judgment" subjected him to a state-law disciplinary scheme entirely external to ERISA's remedial provisions, the Supreme Court of Missouri flatly contradicted the Eighth Circuit's consistent rule that a "decision not to precertify payment relates directly to [the] administration of benefits," *Kuhl*, 999 F.2d at 303, and is thus preempted by ERISA §§ 502 and 514(a), notwithstanding the fact that "[p]lan administrators necessarily exercise medical judgment in determining benefits due under the plan." *Hull*, 188 F.3d at 943; *Kuhl*, 999 F.2d at 303; *Painter*, 121 F.3d at 440; *Thompson*, 202 F.3d at 1073. The decision below thus creates an unworkable and highly unstable division of authority between the state and federal courts sitting in Missouri.

2. The decision below *also* conflicts with the decisions of virtually every *other* court of appeals. Relying on *Pilot Life*, the lower federal courts have uniformly concluded that state-law claims that essentially seek review of benefits determinations

necessarily "relate to" ERISA plans within the meaning of section 514(a).[6] Indeed, several courts have applied ERISA preemption to state law claims challenging adverse utilization review determinations virtually identical to the one made by Dr. Fallon in this case.

Thus, in *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999), the First Circuit held that ERISA completely preempted a state-law negligence claim against a plan administrator for failing to precertify certain medical treatment. 185 F.3d at 2.

[6] *See, e.g.*, (in circuit order) *Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196, 199 (1st Cir. 1997) (ERISA preempted claims arising from refusal to authorize coverage for bone marrow transplant, because a "plan administrator's refusal to pay allegedly promised benefits" is "related to" an employee benefit plan); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 274 (3d Cir. 2001) (ERISA completely preempts negligence and other state law claims arising from delay in approving requested services because such delay was "conduct falling squarely within [the] administrative function"); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 941 (6th Cir. 1995) (holding that state-law claims for wrongful death, medical malpractice, and insurance bad faith arising from allegedly improper utilization review determination were completely preempted because the claims "[arose] from an allegedly improper denial of benefits"); *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1008 (9th Cir. 1998) (ERISA preempted claims arising from delay in authorizing bone marrow transplant, because "the state law in its application directly 'relates to' the administration and disbursement of ERISA plan benefits") (quotation and citation omitted); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991) (ERISA preempted direct liability claims against plan administrator, because "[t]he factual basis for each of plaintiff's state law claims directly concerns the alleged improper administration of the benefit plan"); *Engelhardt v. Paul Revere Life Ins. Co.*, 139 F.3d 1346, 1353 (11th Cir. 1998) (same).

The court recognized that the "allegedly negligent decisionmaking . . . at issue here may be characterized as medical in nature," *id.* at 5—indeed, the court noted that "from the perspective of the patient, [an adverse] prospective utilization review [can have] the same effect as a failure to treat," *id.* at 5 n.6—but held that "[w]hat matters . . . is that the conduct [of the plan administrator] was indisputably part of the process used to assess a participant's claim for a benefit payment under the plan." *Id.* at 6.

Similarly, in *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996), the Seventh Circuit held that a state claim against a utilization review administrator for the allegedly negligent provision of treatment is completely preempted by section 502(a). 88 F.3d at 1490. The plaintiff in *Jass* claimed that a registered nurse performing utilization review for Prudential "negligently and carelessly failed to see that the Plaintiff received appropriate [treatment]." *Id.* at 1488. The court held that the allegedly negligent "determin[ation] that said course of treatment was not medically necessary" and the resulting decision to discharge the plaintiff from the hospital "was a determination of benefits within the meaning of ERISA." *Id.* at 1489 (internal quotation marks omitted). As such, the state law claim was "in effect a claim for denial of benefits" under section 502(a) and was completely preempted. *Id.* at 1489, 1490-91.

Finally, the Fifth Circuit in *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), recognized that in undertaking prospective utilization review, "United makes medical decisions as part and parcel of its mandate to decide what benefits are available under the . . . plan." *Id.* at 1332. Nonetheless, the court held that state law claims challenging utilization review decisions are preempted, because even though "[t]he nature of the benefit determination is

different than the type of decision that was at issue in *Pilot Life*, . . . it is a benefit determination nonetheless." *Id.*; *see also Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000) (holding that a state statute requiring independent physician review where plan member and administrator disagree over whether treatment is "medically necessary" is preempted by ERISA § 514), *on reh'g*, 220 F.3d 641 (same), *petition for cert. filed* No. 00-665 (Oct. 24, 2000).

Each of those cases recognizes that although cost-containment practices such as utilization review and "medical necessity" determinations may entail the exercise of medical judgment, they are nonetheless acts of plan *administration* reviewable only in accordance with the provisions of section 502(a). The conclusion below that a state regulatory body has authority to review those administrative determinations squarely conflicts with those cases.

3. That conflict warrants this Court's attention. This Court has repeatedly stated that review is warranted where, as here, the decision of a highest state court conflicts with a decision of the court of appeals with jurisdiction over that state. *See Madsen v. Women's Health Center, Inc.*, 512 U.S. 753, 755 (1994) (granting certiorari to resolve conflict between the Supreme Court of Florida and Eleventh Circuit); *Lockhart v. Fretwell*, 506 U.S. 364, 368 (1993) (disagreement between Eighth Circuit and Arkansas Supreme Court); *Yee v. City of Escondido*, 503 U.S. 519, 538 (1992) (conflict between Ninth Circuit and Supreme Court of California); *Walton v. Arizona*, 497 U.S. 639, 644 (1990) (conflict between Supreme Court of Arizona and Ninth Circuit); *Baldwin v. Alabama*, 472 U.S. 372, 374 (1985) (conflict between Supreme Court of Alabama and Eleventh Circuit); *see generally Braxton v. United States*, 500 U.S. 344, 347 (1991) ("A

principal purpose for which we use our certiorari jurisdiction . . . is to resolve conflicts among the United States courts of appeals and state courts concerning the meaning of provisions of federal law."). Review is particularly warranted here because the decision below conflicts *not only* with the holding of the Eighth Circuit, but also with the several *other* courts of appeals that have held alternative review mechanisms established by state law preempted by ERISA. *See, e.g.*, *Danca*, 185 F.3d at 8; *Jass*, 88 F.3d at 1489; *Corcoran*, 965 F.2d at 1329. Plenary review is therefore not only appropriate but *essential* to restore uniformity to the principles governing the administration of ERISA plans.

III. The Question Presented Is An Important And Recurring One.

Review is also warranted because the question presented is of recurring and substantial importance. As this Court has recognized, managed care companies must allocate coverage for health care on the basis "of medical necessity or the reasonableness of the proposed treatment" in order to remain financially viable. *Pegram*, 530 U.S. at 219-20 (noting that "no HMO organization could survive" without such a form of utilization review). Those cost-containment practices would be impossible to administer effectively, however, if state medical boards—under the guise of regulating the professional qualifications of plan agents—were permitted to "second guess" coverage decisions made by plan administrators. Facing potential discipline by licensing authorities, medical directors will be inclined to process coverage requests in a manner calculated to avoid such scrutiny, rather than in accordance with their professional judgment about what plan documents require, subject to review under federal standards. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 114-15 (1989). Inevitably, ERISA-governed health plans will be forced to provide benefits for whatever

treatment state licensing authorities deem "medically necessary"—regardless of how that term is defined in their subscriber contracts—solely to avoid subjecting their utilization review staff to disciplinary action. This case therefore has enormous implications for the continuing viability of utilization review.

The question presented is also a recurring one. The complaint against Dr. Fallon is only one of many complaints recently filed with state medical boards against medical directors and other utilization review personnel arising from allegedly improper benefits determinations. *See, e.g., United Healthcare Ins. Co. v. Levy*, 114 F. Supp. 2d 559, 565 (N.D. Tex. 2000) (holding that ERISA preempts a state medical board's authority to discipline a physician for making improper utilization review determinations); *Kirschner v. Mills*, 274 A.D.2d 786, 780 (N.Y. 2000) (physician who performs independent medical exam for insurance purposes is subject to jurisdiction of state medical board); *Murphy v. Board of Medical Examiners*, 949 P.2d 530, 533 (Az. App. 1997) (medical director is subject to board supervision when making "medical necessity determinations"); *Morris v. District of Columbia Bd. of Medicine*, 701 A.2d 364, 364-65 (App. D.C. 1997) (reversing state medical board's determination that medical director practiced medicine without a license by performing utilization review services for Blue Cross and Blue Shield); Dick Kaukas, *Insurer's Doctor Faces Medical Board Action*, THE LOUISVILLE COURIER-JOURNAL (November 4, 1999) (reporting investigation by state medical board into determination by the medical director of Blue Cross and Blue Shield that certain treatment prescribed for a plan member was not "medically necessary").

Filing a complaint with state medical boards has effectively become the "back door" way to attempt to circumvent ERISA's preemption of direct liability

claims against plan administrators. Francis J. Serbaroli, *HMO Medical Directors And Professional Sanctions*, NEW YORK LAW JOURNAL at 3 (June 3, 1998) ("While the political and legal maneuvering to create new malpractice liabilities for HMOs proceeds, an interesting twist has arisen, a kind of 'back door' liability, in which the medical directors of managed care may be subject to professional discipline for negligence in carrying out their job responsibilities"); Nancy Ann Jeffrey, *There's A New Threat For HMOs: Rash Of Doctor Discipline Boards*, THE WALL STREET JOURNAL at B4 (July 13, 1998) ("Doctors have a new way to fight back against health-maintenance organizations that deny coverage: They are taking their complaints to state medical boards."); Jean Lawrence, *Revenge Of The Reviewed*, HOSPITALS AND HEALTH NETWORKS, No. 8, Vol. 73, p 10 (Aug. 1, 1999) ("Because [ERISA] shields employer-sponsored health plans from most state regulation and lawsuits, more angry enrollees are taking a back route—fighting HMOs by undermining their medical directors through state medical boards").

Indeed, in recent years state laws requiring HMO medical directors to be licensed physicians have proliferated. Twenty-six States now require HMO medical directors to be licensed physicians, and twenty of those states further require that the medical director hold a medical license in the State in which the plan is present—a requirement that by definition subjects the medical director to the jurisdiction of the state medical board.[7] In light of those enactments, the alarming rate

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[7] *See* ALA. ADMIN. CODE R. 420-5-6-.02 (2000); ARIZ. REV. STAT. 20-2510 (2001); ARK. ADMIN. CODE HMO § III(T) (2001); CAL. HEALTH & SAFETY CODE SEC. 1367.01(c) (2001); DEL. CODE ANN. TIT. 16, § 9112(b); FLA. STAT. ANN. § 641.51(4) (2001); HAW. REV. STAT. ANN. § 432E-1.5 (2000);

[footnote continued on next page]

at which plan members and others file complaints against utilization review personnel can only be expected to increase.

CONCLUSION

The petition for a writ of certiorari should be granted. [8]

[Footnote continued from previous page]

KY. REV. STAT. ANN. § 304.17A-545(1)(a) (2001); MD. CODE ANN., HEALTH-GEN. § 19-708(b)(6)(ii) (2000); MO. ANN. STAT. § 376.1361.2 (2001); NEV. REV. STAT. 695G.110 (2001); N.H. REV. STAT. ANN. § 420-E:2-a (2001); N.J. STAT. ANN. § 26:2S-6 (2001); N.C. GEN. STAT. § 58-50-61 (2001); OKLA. ADMIN. CODE § 310:655-17-2 (2001); R.I. Admin. Code Health Fac. § 10.1 (2001); 28 TEX. ADMIN. CODE § 11.1606(d)(1)(A) (2001); VT. STAT. ANN. TIT. 26, § 1402 (2000); VA. CODE ANN. § 32.1-138.6 (2000); WASH. REV. CODE ANN. § 48.43.540 (2001).

[8] The Court recently granted certiorari in *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021, to consider whether Illinois' "external review" statutes are preempted by ERISA. *See* 121 S. Ct. 2589, 69 U.S.L.W. 3807 (June 29, 2001). Because the Seventh Circuit concluded (and the parties agreed) that the external review statutes at issue "relate to" an ERISA plan (*see* 230 F.3d 959, 968 (7th Cir. 2000))—a conclusion reached by the Fifth Circuit in reviewing an ERISA preemption challenge to a materially identical Texas statute (*see Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526, 537 (5th Cir. 2000))—and because the parties vigorously contest whether those statutes are saved from preemption as laws that regulate insurance (the issue on which *Rush Prudential* and *Montemayor* conflict (*see* 230 F.3d at 969-71)), *Rush Prudential* seems more likely to turn on the insurance savings clause of ERISA, 29 U.S.C. § 1144(b)(2)(A), than on the preemptive scope of Section 514(a). For that reason, plenary review is appropriate in this case notwithstanding the pendency of *Rush Prudential*.

[footnote continued on next page]

Respectfully submitted.

RICHARD J. PAUTLER
LEWIS R. MILLS
THOMPSON COBURN LLP
One Firstar Plaza
St. Louis, MO 63101
(314) 552-6470

MIGUEL A. ESTRADA
Counsel of Record
THOMAS G. HUNGAR
ANDREW S. TULUMELLO
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

Counsel for Petitioner

August 8, 2001

[Footnote continued from previous page]

This Court also has before it a petition for certiorari in *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001) ("*Pappas II*"). *See United States Healthcare Sys., Inc. v. Pennsylvania Hosp. Ins. Co.*, No. 01-200 (petition filed Aug. 1, 2001). This Court previously granted certiorari and vacated the judgment in *Pappas v. Asbel*, 555 Pa. 342, 724 A.2d 889 (1998) ("*Pappas I*")—a case in which it had invited the Solicitor General to express the views of the United States (*see* 528 U.S. 804)—for reconsideration in light of *Pegram*. *See* 530 U.S. 1241. *Pappas II* presents the question whether ERISA preempts state law direct liability claims against a plan arising from allegedly improper coverage determinations. Because *Pappas II*, like this case, addresses the extent to which ERISA preempts state laws that purport to authorize alternative review mechanisms to ERISA § 502(a), it would be appropriate for this Court to grant certiorari in both cases and consider them together. In the event the Court elects to review only one of the two decisions, the Court should hold this petition pending its consideration and disposition of *Pappas II*.

APPENDIX

STATE BOARD OF REGISTRATION
FOR the HEALING ARTS,
Respondent,

v.

Richard FALLON, M.D., Appellant.

No. SC 82841.

Supreme Court Of Missouri,
En Banc.

41 S.W.3d 474

April 10, 2001.

PRICE, Chief Justice.

Dr. Richard Fallon appeals an order of the circuit court requiring him to appear before the State Board of Registration for the Healing Arts (the Board). He contends that the Employee Retirement Income Security Act of 1974 (ERISA) preempts Missouri law insofar as it grants the Board authority to review medical decisions made on behalf of an employee benefit plan. Because Dr. Fallon's actions in this case involved the exercise of medical training and judgment, the Board is empowered to review his actions as a licensed physician. The judgment of the circuit court is affirmed.

I. Facts

Dr. Fallon is a state-licensed physician and surgeon. Until recently, he was employed as a medical director for Prudential Health Care (Prudential), which administers an employee benefit plan. In his capacity as medical director, Dr. Fallon made decisions concerning the "medical necessity" of certain treatments. Based on his medical

judgment, Prudential would either extend or deny coverage of medical expenses to plan participants.

On January 27, 1999, the Board received a complaint from Dr. Duane Keller, an oral surgeon, regarding Dr. Fallon's determination that a requested surgical procedure was "not medically necessary." Shortly thereafter, the Board began an investigation into the complaint. On November 23, 1999, the Board issued a subpoena to Dr. Fallon, which ordered him to meet with the Board's medical staff for an interview on December 8, 1999. Dr. Fallon failed to appear.

As required by section 334.127.2,[1] the Board sought to enforce the subpoena by petitioning the Circuit Court of Cole County. On June 22, 2000, the circuit court entered its final judgment ordering Dr. Fallon to appear before the Board within sixty days on a date agreed upon by counsel. The circuit court then stayed the judgment to afford Dr. Fallon an opportunity to exhaust his appeals.

II. Discussion

Dr. Fallon cites three points of error in the judgment of the circuit court. First, he contends that ERISA "superceded and invalidated" Missouri law to the extent that it authorized the Board to investigate matters related to an employee benefit plan. Second, he argues that chapter 334, RSMo 2000, does not authorize the Board to investigate "utilization review" cases. Finally, he argues that his decisions as medical director did not involve the practice of medicine or

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[1] "The board may enforce its subpoenas, including subpoena duces tecum, by applying to a circuit court of Cole County, the county of the investigation, hearing or proceeding, or any county where the person resides or may be found, for an order upon any person who shall fail to obey a subpoena to show cause why such subpoena should not be enforced . . . ." Section 334.127.2, RSMo 2000.

any other conduct that could lead to disciplinary actions under section 334.100, RSMo 2000. We address each of these contentions in turn.

A.

Section 514(a) of ERISA states that the act "shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. section 1144(a). The Act further defines "state law" to include "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." 29 U.S.C. section 1144 (c)(1).

Whether ERISA pre-empts the Board's action in this case turns on whether the Board's investigation "relates to" the employee benefit plan. The United States Supreme Court has determined that a state law "relates to" an employee benefit plan when it "has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983). Clearly, the statute authorizing the Board's action in this case does not "reference" any employee benefit plan. *See* section 334.127, RSMo 2000. The statute simply grants the Board authority to subpoena witnesses and documents when conducting investigations related to the conduct of state licensees. *Id.*

Thus, the inquiry in this case is whether the state action has a "connection with" an employee benefit plan. *Shaw*, 463 U.S. at 97, 103 S. Ct. 2890. In theory, infinite connections could exist that would allow a court to find any state law to have a connection with an employee benefit plan. However, the United States Supreme Court concluded that "[f]or the same reasons that infinite relations cannot be the measure of preemption, neither can infinite connections." *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995); *see also Egelhoff v. Egelhoff*, 532 U.S. —, — 121 S. Ct. 1322, — L. Ed. 2d — (2001). In *Travelers,*

the Court noted that the "historic police powers of the States were not to be superceded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.* at 655, 115 S. Ct. 1671, 131 L. Ed. 2d 695. The Court further found that the "historic police powers of the State include the regulation of matters of health and safety." *De Buono v. NYSA-ILA Med. and Clinical Serv. Fund*, 520 U.S. 806, 814, 117 S. Ct. 1747, 138 L. Ed. 2d 21 (1997).

The United States Supreme Court has also focused on the effect of state action on the employee benefit plan. The Court concluded that a state law causing an indirect burden on an employee benefit plan may not trigger preemption. *See Travelers Ins. Co.*, 514 U.S. at 668, 115 S. Ct. 1671. Nevertheless, the Court found that a state law "might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted under section 514." *Id.* For example, ERISA pre-empts state laws that provide alternative enforcement mechanisms for plan beneficiaries or laws that interfere with employee benefit structures or their administration. *Id.* at 658, 115 S. Ct. 1671; *see also Thompson v. Gencare Health Systems, Inc.*, 202 F.3d 1072 (8th Cir. 2000).

The determinations at issue in this case fall outside the scope of plan administration. Dr. Fallon did not simply look to a predetermined list of covered procedures to arrive at his conclusions. He used medical training and judgment to make a decision about the "medical necessity" of surgical treatment for a particular patient. This medical judgment is analytically distinct from the coverage policies adopted by the employee benefit plan. Though the choice to cover a patient's expenses is an administrative choice, a physician's finding of "medical necessity" is a purely medical decision. The Missouri legislature has charged the Board or Registration for the Healing Arts with reviewing the medical judgments of state

licensees. *See* section 334.100.1, RSMo 2000. Whether such medical judgment is exercised by a physician providing direct treatment or by a physician during a utilization review is merely coincidental to the Board's review power.

The Board's review of Dr. Fallon's medical decisions will not mandate any particular benefits structure or provide an alternative mechanism for a plan beneficiary to enforce any particular claim. *See Travelers*, 514 U.S. at 658, 115 S. Ct. 1671. The plan beneficiary in this case will not be able to enforce her claim through the Board's investigation or disciplinary proceedings. Nor will the beneficiary be able to bring a claim against Dr. Fallon for medical malpractice. *Hull v. Fallon*, 188 F.3d 939, 943 (8th Cir. 1999), *cert. denied,* 528 U.S. 1189, 120 S. Ct. 1242, 146 L. Ed. 2d 101 (2000); *see also Thompson*, 202 F.3d at 1073 (8th Cir. 2000). The Board is simply initiating an investigation to ensure that Dr. Fallon is using "that degree of skill and learning ordinarily used under the same or similar circumstances by the member of the applicant's or licensee's profession." Section 334.100.2(5), RSMo 2000. Though ERISA may pre-empt state laws that interfere with coverage decisions, it does not prevent the state from exercising its traditional police powers to review the medical judgments of one of its licensed physicians. The point is denied.

B.

In his second point, Dr. Fallon contends that the trial court erred in entering final judgment because the Missouri legislature has not granted the Board authority to investigate "utilization review" cases. He argues that the legislature vested such authority in the Department of Insurance.

In 1997, the Missouri legislature granted the Department of Insurance extensive supervisory power over utilization review. *See* section 374.500 *et seq.,* RSMo 2000; section 376.1350 *et seq.,* RSMo 2000. While this statutory scheme provides a detailed regulatory framework for reviewing the

administrative decisions of utilization review agents, it does not grant the Department of Insurance any authority to review the medical judgments of licensed physicians who serve as medical directors. *Id.* As stated before, the review authorized by the Board is not concerned with "utilization review" or the administration of insurance benefits. It is simply a review of the exercise of licensed medical judgment in accordance with the state's traditional police powers. The Department of Insurance has no authority to conduct such a review. The Board is charged with overseeing Dr. Fallon's medical judgment, while the Department of Insurance regulates his administrative insurance determinations. The point is denied.

C.

In his final point, Dr. Fallon contends that the trial court erred in entering final judgment because chapter 334 does not authorize an investigation into the type of conduct at issue in this case. Specifically, he argues that his conduct could not lead to discipline under section 334.100 because his decision was nothing more than an initial determination that the employee benefit plan would not pre-certify benefits for the surgical procedure.

Dr. Fallon's argument ignores the distinct nature of the two determinations in this case. Prudential made an *administrative* decision when it determined that the plan would not extend benefits to cover this type of elective surgery unless the medical director found it to be "needed and appropriately provided." Dr. Fallon then made a purely *medical* decision when he determined that the procedure was "not medically necessary." Though his decision naturally led to a denial of coverage, the decision embodied the medical judgment of a licensed professional who determined whether a certain procedure was medically necessary for a specific patient.

The Arizona Court of Appeals addressed a similar argument in *Murphy v. Board of Medical Examiners*, 190 Ariz. 441, 949 P.2d 530 (Ariz. Ct. App. 1997). In *Murphy*, the court considered whether the Board of Medical Examiners of the State of Arizona had jurisdiction to discipline "a licensed physician whose position as medical director for a managed health care company requires him to render decisions that potentially affect patients' medical care." *Murphy*, 949 P.2d at 535. The court noted that Dr. Murphy was not engaged in the "traditional practice of medicine." *Id.* at 536. Nevertheless, the court found that Dr. Murphy substituted his medical judgment for that of the treating physicians in determining that the proposed surgical procedure was "not medically necessary." *Id.* In holding that the Board of Medical Examiners may discipline the license of a medical director, the court concluded, "There is no other way to characterize Dr. Murphy's decision: it was a 'medical' decision." *Id.*

"[T]he obvious intention of Chapter 334 is to embrace 'any person who habitually holds himself out as a professor of the art of healing.'" *State ex rel. Collet v. Scopel*, 316 S.W.2d 515, 519 (Mo. 1958). Dr. Fallon's medical judgment is subject to oversight by the Board, which is empowered to impose discipline under section 334.100.2. The point is denied.

III. Conclusion

The judgment of the circuit court is affirmed.

LIMBAUGH, WHITE, HOLSTEIN, WOLFF and BENTON, JJ., and WALLACE, Sp. J., concur.

LAURA DENVIR STITH, J., not participating.

IN THE CIRCUIT COURT OF COLE COUNTY
STATE OF MISSOURI

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS, 3605 Missouri Blvd. P.O. Box 4 Jefferson City, MO 65102	)	
Petitioner,	)	
v.	)	Case No. 00CV323008
RICHARD FALLON, M.D., 12312 Olive Blvd., Suite 500 St. Louis, MO 63141	)	
Respondent.	)	

FINAL JUDGMENT ENFORCING THE SUBPOENA DUCES TECUM ISSUED BY THE BOARD UPON DR. FALLON

Based upon the argument and record filed, including but not limited to Respondent's Motion to Reconsider filed April 18, 2000, the Court makes the following findings of fact and conclusions of law and enters the following order and final judgment:

1. This Court has jurisdiction in this cause under § 334.127.2, RSMo 1994.

2. Venue is proper in Cole County pursuant to § 334.127.2, RSMo 1994.

3. The State Board of Registration for the Healing Arts ("Board") is an agency of the State of Missouri created and established pursuant to § 334.120, RSMo 1994, for the

purpose of executing and enforcing the provisions of Chapter 334, RSMo 1994. *See* § 334.120.

4. Respondent, Richard Fallon, M.D., is licensed by the Board as a physician and surgeon, license number MDR2602, which license was first issued March 21, 1964. Dr. Fallon's certificate of registration is current and active.

5. At all relevant times, Dr. Fallon was a Medical Director for Prudential Health Care (PHC). He served in that capacity on a full-time basis between November 1988 and December 1999 when he became totally disabled as a result of a heart attack. He is now a resident of the state of Florida.

6. PHC, as set out in its written employee health benefits policies or plans (hereinafter "Plan"), provides monetary benefits to pay for certain, specified and covered medical services and supplies received by eligible PHC participants. A Plan does not necessarily provide benefits for all medical treatment, care, and services that a Plan participant might seek or receive. The Plan does not provide benefits for procedures or services it concludes are not "medically necessary" as that term is defined in the Plan. As a Medical Director, one of Fallon's responsibilities was to participate in the administration of the Plan by determining whether such benefits were or would be due and owing under the terms of the Plan.

7. The decision whether certain medical services or procedures will be pursued is between the patient and his or her doctor and neither Fallon nor the Plan may prevent such services or procedures from being performed.

8. PHC is also a "utilization review agent" within the meaning of § 374.500(6), RSMo and performs "utilization review" within the meaning of § 374.500(5), RSMo as a regular part of its plan administration. "Utilization Review" is defined statutorily as follows:

> (5) "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

As Medical Director for PHC, Dr. Fallon performs this "utilization review" for PHC as a part of his plan administration.

9. Missouri expressly vests the Missouri Department of Insurance with responsibility to oversee utilization review and enforce the laws governing utilization review. See, § 374.500, RSMo.

10. In addition, Missouri statutes allow a person with a grievance arising out of utilization review process to assert that grievance. The grievance is handled through the Missouri Department of Insurance. See, § 376.1375, RSMo. The Board is not identified in § 376 as having any role in the grievance procedure.

11. Despite its finding in paragraphs 8, 9, and 10, the Court does not believe the Petitioner is barred from reviewing Fallon's utilization review actions as Medical Director.

12. In the case of patient V.G., upon inquiry being made of Fallon, he made the initial determination, as Medical Director administering a benefit determination under the Plan, that the terms of the Plan did not support the precertification of benefits for TMJ surgery proposed for V.G. because he did not find that the surgery was "medically necessary" within the meaning of the Plan.

13. Fallon's sole and exclusive involvement in V.G.'s care was making the determination of whether or not benefits would be available for V.G.'s TMJ surgery under the terms of the Plan.

14. Fallon never attempted or purported to assume responsibility for her medical care or treatment. He never saw or examined V.G. He never spoke to V.G. He never prescribed any medication or course of treatment for V.G. He never counseled against any form of treatment for V.G. He never took any action regarding V.G. other than to make benefit determinations through his responsibilities as Medical Director of PHC.

15. On January 27, 1999, the Board received a complaint against Dr. Fallon from Dr. Duane Keller regarding the action of Dr. Fallon in denying insurance coverage for a requested medical procedure for patient V.G.

16. Patient V.G. appealed the denial of coverage for the TMJ surgery through the internal Prudential Health Care process.

17. On March 23, 1999, PHC mailed Patient V.G. a letter which reversed the decision of Dr. Fallon and pre-certified the TMJ surgery.

18. Pursuant to § 334.127.1, RSMo 1994, the "President or secretary of the board may. . .subpoena witnesses, issue subpoenas duces tecum and require production of documents and records."

19. On November 23, 1999, the Board, based upon the Board's receipt of a complaint from Dr. Duane Keller regarding the denial of benefits for patient V.G., subpoenaed Dr. Fallon to appear at the Board's office in Jefferson City for an interview with the Board's medical staff. Dr. Fallon was also directed to bring a variety of records with him to the interview. The stated purpose of subpoena was to question Dr. Fallon regarding the Board's investigation into "your

denial of surgical insurance coverage on patient V.G. and the reason for said denial and the communications following said denial pursuant to § 334.100.2, RSMo."

20. Dr. Fallon was directed to appear at the Board's office on December 8, 1999 at 1:15 p.m. Dr. Fallon's counsel advised the Board's counsel that Dr. Fallon and his employer did not believe the subpoena was proper and that Dr. Fallon intended to challenge the propriety of the subpoena so that he would not appear at the Board's office on December 8, 1999. Dr. Fallon did not in fact appear before the Board on December 8, 1999. Thus, the Court finds that he failed to honor a subpoena issued by the Board pursuant to § 334.127.1, RSMo.

IT IS HEREBY ORDERED, ADJUDGED and DECREED that Petitioner's requests contained in its Application are hereby enforced. The Respondent, Richard Fallon, M.D., is ordered to comply with the subpoena *duces tecum* issued by the Board. The Respondent shall appear at the offices of the Board pursuant to the terms of the subpoena duces tecum issued by the Board on November 23, 1999 at a date within 60 days to be determined by the parties.

The effect of this Final Judgment shall be stayed pending the exhaustion of Respondent's appeals or further order of this Court.

SO ORDERED this 22nd day of June, 2000.

/s/
Thomas J. Brown III, Judge
Cole County Circuit Court
Division I

IN THE CIRCUIT COURT OF COLE COUNTY, MISSOURI

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS,	)	
Petitioner,	)	
v.	)	Cause No. 00CV 323008
DR. RICHARD FALLON,	)	
Respondent.	)	

DR. RICHARD FALLON'S MOTION TO RECONSIDER

MOTION TO RECONSIDER ORDER ENFORCING THE SUBPOENA DUCES TECUM ISSUED BY THE BOARD UPON DR. FALLON

Respondent Richard Fallon moves the Court to reconsider its Order of April 4, 2000, enforcing the subpoena *duces tecum* issued to him by the Board, on the grounds that the state law pursuant to which the Board is purporting to act has been preempted by federal law, to-wit: Section 514(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1144(a). That federal statute provides that ERISA **"shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan**" subject to the statute. The subpoena at issue in this proceeding relates to a denial of benefits to a participant or beneficiary of an ERISA plan, and therefore any state law authorizing its issuance is preempted by ERISA section 514(a). See *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999), *cert. denied*, 68 U.S.L.W. 3433, 2000 WL 220289 (U.S. Feb. 28, 2000) (No. 99-1083).

THOMPSON COBURN LLP

By /s/

Richard J. Pautler #30789
One Firstar Plaza – 34th Floor
St. Louis, MO 63101
(314) 552-6000 (telephone)
(314) 552-7000 (telecopy)
rpautler@thompsoncoburn.com (e-mail)
Attorneys for Respondent

CERTIFICATE OF SERVICE

The undersigned counsel hereby certifies that a copy of the foregoing was served upon James O. Ertle, Missouri Attorney General's Office, P.O. Box 899, Jefferson City, MO 65102 by United States first class mail, postage prepaid, this 10th day of April, 2000.

/s/
Richard J. Pautler

IN THE CIRCUIT COURT OF COLE COUNTY, MISSOURI

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS,	)	
Petitioner,	)	
v.	)	Cause No. 00CV 323008
DR. RICHARD FALLON,	)	
Respondent.	)	

DR. FALLON'S RESPONSE TO PETITIONER'S REPLY TO HIS MOTION TO RECONSIDER

Dr. Fallon's motion to reconsider is based on Section 514(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1144(a). That section provides that ERISA **"shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"**.

In its Reply to Dr. Fallon's motion to reconsider, the Petitioner argues that §334.127 RSMo, the statutory provision under which it issued the subpoena, is not preempted by ERISA §514(a), because §334.127 does not **"relate to"** an employee benefit plan.

Respondent's First Argument: Respondent's first ground for this argument is that §514(a) preempts only state laws and therefore cannot preempt a subpoena. This argument is simplistic at best. If, as Dr. Fallon argues, §514(a) is applicable in this case, it preempts §334.127 "insofar as" that

statute authorizes the subpoena at issue in this case. [1] What is preempted is the statute (as applied in this case). The **effect** of that preemption is the invalidation of the subpoena.

Respondent's Second Argument: Respondent's second ground is that §334.127 cannot be preempted because it does not refer to employee benefit plans. But *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983), a case cited by Respondent, holds that "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." (Emphasis added) The criteria are stated in the disjunctive, and there is therefore a two phase inquiry:

1. Does the state law refer to an employee benefit plan?
2. If it does not, does the state law nevertheless have a connection with such a plan?

Respondent's argument negates only the first phase of this inquiry. Finding that that the statute does not refer to a employee benefit completes only the first phase of this prescribed two-phase inquiry. *Prudential Insurance Co. of America v. National Park Medical Center, Inc.*, 154 F.3d 812, 813 (8th Cir. 1998): "Thus, where there was no 'reference to' ERISA in the state law, **the court's further preemption inquiry** was governed by the objectives of the ERISA statute as a guide to what state laws Congress intended to preempt." (Emphasis added)

Indeed, the United States Supreme Court in *Ingersoll Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) noted that "Under this "broad common-sense meaning," a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if

---

[1] Section 334.127 is of course not totally preempted. What is involved here is only a limited "insofar as" preemption.

the law is not specifically designed to affect such plans, or the effect is only indirect." *See also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

Thus the determinative issue is not whether §334.127 expressly refers to employee benefit plans. It is, rather, whether that statute as applied in this case "has a connection with" an employee benefit plan.

In one (and perhaps overly philosophical) sense, everything has a connection with everything else. Certainly the test for ERISA preemption is not that broad; *see, e.g., Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126 (7th Cir. 1992) (the state law claim of a person who slips on a banana peel in the office of an employee benefits plan is not preempted.)

Rather, the scope of the preemption of §514(a) is limited by the purposes and policies of the Employee Retirement Income Security Act of 1974, as amended, of which it is a part. *Prudential Insurance Co. of America v. National Park Medical Center, Inc., supra.* In enacting ERISA, Congress did not require every employer to provide benefits to its employees. Rather, it used a number of carrots rather than a stick. It included in ERISA several protections and inducements to encourage employers voluntarily to provide benefits to their employees. **One of the carrots was freedom from state interference. That carrot is embodied in ERISA §514(a).**

That freedom is not unlimited. Only those activities inherent in or necessarily incidental to providing benefits are protected from state interference. As noted above, an employee benefit plan may still be liable under state law to a person who slips on a banana peel in its office. *Pohl v. National Benefits Consultants, Inc., supra.* But subject to that limitation, the freedom from state interference is

"conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990).

Granting and denying benefits are an essential part of administering any employee benefit plan. What is at issue in this case is the power of the Respondent to compel Dr. Fallon to testify about a denial of benefits to a beneficiary of an employee benefit plan. Respondent seeks testimony about conduct that was an essential part of the operation of that plan. Clearly, then, the subpoena "has a connection with" that plan. Insofar as §334.127 authorizes that subpoena, it too has a connection with the plan, and to that extent it too is preempted by §514(a). In short, as Judge Posner succinctly stated, "This is not a banana peel case." *Pohl*, *supra* at 128. This case, rather, is a deliberate attempt by Respondent to pry into the affairs of an employee benefit plan. Federal law prohibits that effort.

Third: Finally, Respondent argues that *Hull v. Fallon* is not in point because it involved ERISA §502 rather than §514(a). This argument overlooks the intimate relation between §502 and §514(a).

The doctrine of "complete preemption" is based on §502; see *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). The doctrine relates to the jurisdiction of the federal courts, and not to the substantive merits of the claims before the court. Under this doctrine any claim that is in fact based on a denial of benefits under an employee benefit plan is within the jurisdiction of the federal courts, whether or not that factual basis appears on the face of the pleadings; it is simply an exception to the "well pleaded complaint" rule of federal jurisdiction. But any claim that is within the jurisdiction of the federal courts under the doctrine of complete preemption necessarily has "a connection with" an employee benefit plan. Consequently, if and to the extent that such a "completely preempted" claim is based on state law, that state law is also preempted by §514(a). *Heiman v. National*

Elevator Industry Pension Fund, 187 F.3d 493, 502 (5th Cir. 1999). In short, the set of claims "completely preempted" under §502 is completely included in the set of claims preempted under §514(a).

Thompson v. Gencare Health Systems, Inc., 2000 WL 15094 (8th Cir. 2000), illustrates this connection between §502 and §514(a). There the plaintiff sued the administrator of an employee benefit plan in state court, alleging that the defendant committed medical malpractice by failing to pre-certify a particular form of treatment. The defendant removed the case to federal court under the doctrine of complete preemption (§502) and moved to dismiss on the ground that the plaintiff's state law claim for malpractice was preempted under §514(a). On the jurisdictional issue, the federal district court denied the plaintiff's motion to remand. On the substantive issue, it granted the defendant's motion to dismiss. On appeal, the United States Court of Appeals affirmed the judgment in favor of the defendant. Thus *Thompson v. Gencare Health Systems, Inc.* holds that malpractice claims against an employee benefit plan are preempted by §514(a).

Indeed, the issue of preemption under §514(a) was present in the district court in *Hull v. Fallon* as well. The plaintiff there conceded that if the federal district court had jurisdiction, his state law claims were subject to preemption under §514(a). He did not even appeal that issue.

Conclusion: Respondent's statutory authority to issue subpoenas does not include the power to issue subpoenas that are unrelated to Respondent's statutory duties and responsibilities. In this proceeding it has not identified any statutory duty or responsibility to which its subpoena relates; nor can it do so.

It cannot take any action under §334.100 RSMo against Dr. Fallon's license for his conduct in denying pre-certification of benefits for V.G. His conduct --- which

involved only the administration of an employee benefit plan and not the practice of medicine --- is protected by ERISA from state interference. Yet that conduct is the only subject to which the subpoena relates.

Because the subpoena has a connection with an employee benefit plan, to the extent that §334.127 authorized its issuance §334.127 is preempted by ERISA §514(a). That preemption invalidates the subpoena.

To induce employers to provide benefits to their employees, Congress offered protection against state harassment to those employers who did so. **What Respondent is trying to do here is exactly what Congress intended to prevent.** For this additional reason, the Court should reconsider and withdraw its Order of April 4, 2000.

THOMPSON COBURN LLP

By_____/s/_____

Richard J. Pautler #30789
Lewis R. Mills #15872
One Mercantile Center – 34th Floor
St. Louis, MO 63101
(314) 552-6000 (telephone)
(314) 552-7000 (telecopy)
rpautler@thompsoncoburn.com (e-mail)
Attorneys for Respondent

CERTIFICATE OF SERVICE

The undersigned counsel hereby certifies that a copy of the foregoing was served upon James O. Ertle, Missouri Attorney General's Office, P.O. Box 899, Jefferson City, MO 65102 by United States first class mail, postage prepaid, this 21st day of April, 2000.

/s/
Lewis R. Mills

IN THE CIRCUIT COURT OF COLE COUNTY,
MISSOURI
19TH JUDICIAL CIRCUIT
DIVISION NO. _____

STATE BOARD of REGISTRATION for the HEALING ARTS	)	
vs.	)	Case No. 00CV323008
RICHARD FALLON, M.D.,	)	

APPEARANCES:	ATTORNEY FOR:
James Ertle	STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
Richard J. Pautler	Respondent, Richard Fallon

The Court determines that a final judgment has not been entered in this case. The Court will consider Respondent's Motion to Reconsider prior to entering a final judgment. The parties agree that if final judgment is entered on behalf of Petitioner, such judgment shall be stayed pending the exhaustion of appeals.

Copy to all Attys of Record

☐ SUBMITTED BY:	ATTORNEY FOR:
/s/	Board of Healing Arts
James O. Ertle	Respondent
/s/	SO ORDERED this 3 day of
Richard J. Pautler	May, 2000
	/s/
	JUDGE

NOTICE AND SUBPOENA DUCES TECUM BEFORE THE MISSOURI STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

Richard H. Fallon, M.D.) No. HA01016773
Licensee)

THE STATE OF MISSOURI

TO: Richard H. Fallon, M.D.
12312 Olive Blvd., Suite 500
St. Louis, MO 63141

GREETINGS:

The State Board of Registration for the Healing Arts is investigating your denial of surgical insurance coverage on patient Victoria Grover and the reason for said denial and the communications following said denial pursuant to Section 334.100.2 RSMo. The Board is conducting an investigation into this matter and any other matters that may be brought to the Board's attention concerning any violations of Chapter 334, RSMo. Before any decision is made regarding this matter, the Board has subpoenaed you to appear before the Board's Medical Staff for a taped, investigative interview, which will be conducted under oath, to gather any information which may assist the Board in evaluating the situation.

Therefore, pursuant to Section 334.127, RSMo. 1994, you are hereby directed to appear in person before the Missouri State Board of Registration for the Healing Arts' Medical Staff at 1:15 p.m. on Wednesday, December 8, 1999 in the Conference Room of the Board's office, 3605 Missouri Boulevard, Jefferson City, Missouri 65109. Further you are to bring *any and all* patient records, prescribing logs, billing records, documents, protocols, policies, and/or procedures, summaries, orders, reports, and/or other written

memorializations regarding your denial of surgical insurance coverage on patient Victoria Grover and the reason for said denial and the communications following said denial and should be prepared to respond to any questions regarding this matter.

You may have legal counsel accompany you if you so desire. Please be advised that failure to honor this subpoena is grounds for disciplinary action against your license to practice the healing arts in the State of Missouri pursuant to Section 334.100.2(4)(m), RSMo. 1994. Following your appearance before its Medical Staff the Board may choose to further investigate this matter, file a complaint in the Administrative Hearing Commission or before any other appropriate administrative body or court, or dismiss this matter.

Witness my hand and seal hereunto affixed in the City of Jefferson, County of Cole, State of Missouri, this 23rd day of November, 1999.

/s/

Barry D. Spoon, D.O., President
Missouri State Board of
Registration for the Healing Arts

NOTE If you have any questions concerning this subpoena or about the scheduling of this interview, please contact C.C. Reynolds, M.D. at (573) 751-6641.

* * * *

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the Constitution of the United States provides:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. CONST. art. VI, cl. 2.

ERISA's civil enforcement provision, § 502(a)(1)(B) of the Act, provides in pertinent part:

> A civil action may be brought * * * by a participant or beneficiary * * * to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1132(a)(1)(B).

ERISA's express preemption provision, § 514(a) of the Act, provides in pertinent part:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title * * * *

29 U.S.C. § 1144(a).

ERISA defines "state law" to include:

> All laws, decisions, rules, regulations, or other State action having the effect of law, of any State.

29 U.S.C. § 1144(c)(1).

Supreme Court, U.S.
FILED
SEP 24 2001

No. 01-241

In the
SUPREME COURT OF THE UNITED STATES

RICHARD FALLON, M.D.,
Petitioner,

v.

STATE BOARD OF REGISTRATION
FOR THE HEALING ARTS,
Respondent.

On Petition for a Writ of Certiorari
to the Supreme Court of Missouri

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

JEREMIAH W. (JAY) NIXON
Attorney General of Missouri

JAMES R. LAYTON
State Solicitor
Counsel of Record
RONALD MOLTENI
JAMES O. ERTLE
Assistant Attorneys General
P.O. Box 899
Jefferson City, MO 65102
(573) 751-3321 phone
(573) 751-0774 facsimile

Counsel for Respondent

QUESTION PRESENTED

Whether a state medical licensing board charged with determining the competency of physicians is barred by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA"), from investigating the exercise of medical judgment by a physician when he is employed as the medical director of a managed care organization and exercises medical judgment in the course of assisting that organization in making a benefits determination for an ERISA plan.

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No. 01-241

In the
SUPREME COURT OF THE UNITED STATES

RICHARD FALLON, M.D.,

Petitioner,

v.

STATE BOARD OF REGISTRATION
FOR THE HEALING ARTS,

Respondent.

On Petition for a Writ of Certiorari
to the Supreme Court of Missouri

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

STATEMENT OF THE CASE

This case arose from an attempt by Missouri's State Board of Registration for the Healing Arts ("Board") to do its job: to protect the public health and welfare by determining the competency and qualifications of physicians. The Board was established for "the purpose of registering, licensing and supervising all physicians and surgeons" in Missouri. *See* Mo. Rev. Stat. § 334.120.1 (2000). Among the physicians licensed by the Board is petitioner Richard Fallon, M.D. Until recently, Dr. Fallon was employed as a medical director for Prudential Health Care, which administers employee benefit plans. Such plans often cover only procedures that are medically necessary.

Among the assignments given to medical directors such as Dr. Fallon is the task of determining whether a particular treatment for which a plan participant seeks coverage is medically necessary.

On January 27, 1999, the Board received a written complaint against Dr. Fallon from Dr. Duane Keller, an oral surgeon. Dr. Keller had prescribed a surgical procedure for his patient, V.G.[1]; he complained about Dr. Fallon's determination that the procedure was not medically necessary. The Board reviewed the complaint and began an investigation. On November 23, 1999, the Board issued a subpoena to Dr. Fallon, directing him to meet with the Board's medical staff on December 8, 1999, and to bring documents related to the decision regarding V.G. The Board sought to gather more information regarding the pending complaint – and to allow Dr. Fallon the opportunity to respond to its allegations.

When Dr. Fallon failed to appear on December 8, the Board sought to enforce the subpoena by petitioning the Circuit Court of Cole County, Missouri.[2] On June 22, 2000, the Circuit Court issued a final judgment enforcing the subpoena. The Missouri Supreme Court affirmed that judgment on April 10, 2001.

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[1] Respondent follows the practice of all the courts that have heard this matter, using only the patient's initials to preserve her privacy.

[2] The Board's subpoenas are not self-enforcing. Thus Mo. Rev. Stat. § 334.127.2 (2000) requires that "[t]he Board enforce its subpoenas ... by applying to a circuit court ... for an order upon any person who shall fail to obey a subpoena to show cause why such subpoena should not be enforced."

REASONS TO DENY THE WRIT

This case has a very limited scope. As part of its assignment to protect the public health, the Board determines whether physicians are maintaining the standards necessary for licensure. That task requires that the Board investigate alleged lapses in medical judgment – lapses that show that a physician, if permitted to retain his license, may threaten the health of those who rely on his expertise. In seeking information from Dr. Fallon, the Board was only doing its job – the same job that is performed by licensing boards in all 50 states, covering a wide range of professions. This case involves nothing more than the Board's ability to investigate the competency of a physician.

Dr. Fallon argues that this case is extraordinary. In his view, the fact that the lapse in medical judgment may have occurred in the course of advising a managed care organization as to whether a particular procedure is medically necessary brings it out of the area of traditional state regulation and into conflict with decisions of this and other courts. And in his view, permitting this Board to investigate this exercise of medical judgment signals the beginning of the end for managed care plans providing benefits under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA"). It does neither.

1. Invoking their police power, states endeavor to protect the public health and welfare by licensing many professions, among them physicians. Missouri, like other states, has recognized that errors a physician makes while treating patients are not the only manner in which he may demonstrate that permitting him to retain a license to practice medicine may threaten the public health. Thus if a physician commits a crime or becomes incompetent to practice medicine because of substance abuse, the state can take disciplinary

action against his license — even if neither the crime was committed nor the abuse occurred in connection with the treatment of a patient. *See* Mo. Rev. Stat. § 334.100.2(1) and (22) (2000). By broadly defining the scope of activities that can form the basis for disciplining a license, the state acts prophylactically. It removes licenses – and thus both the legal right to treat patients and the government's implicit endorsement of competency to do so – from physicians who cannot be trusted to act with adequate care and skill, regardless of whether the loss of trust results from errors in a physician's treatment of his own patients.

Here, the Board received a complaint alleging that Dr. Fallon had erred so grievously when evaluating the necessity of a particular treatment that his competency to practice medicine was called into question. Petition at 3. The Board initiated an investigation of Dr. Fallon's medical judgment. It served on Dr. Fallon a subpoena that included a requirement that he bring records relevant to the point at which he applied his medical judgment, *i.e.*, the point at which he determined that the prescribed treatment was not "medically necessary," as required for coverage under V.G.'s plan. As a shorthand way of specifying the type of documents that could be relevant to its investigation, in its subpoena the Board identified potentially relevant documents by reference to the "denial of surgical insurance coverage." Pet. App. at 23a.

While investigating Dr. Fallon's use of medical judgment, the Board was in a position no different from other boards, commission, officers, or courts that regulate licensed professionals who may be employed by ERISA plans. A nurse, pharmacist, accountant, or even a lawyer, employed by a plan, may be asked to use professional judgment in assisting with benefits determinations. In using such judgment, the licensed professional might demonstrate incompetence or some other deficiency. If the appropriate licensing agency determines that

a professional with such a deficiency threatens the public health or safety or is otherwise unqualified to hold and use a license, it may revoke or otherwise limit use of that license.

By enforcing a subpoena to investigate the use of professional judgment in the course of benefits review, licensing agencies act for the public, not for individuals, even for complainants. Licensure investigations do not currently nor retroactively affect "utilization review" or the benefits an ERISA plan provides to any participant or beneficiary. Licensing agencies have only limited authority. They cannot grant relief to any plan participant; they can only protect the public by revoking or limiting use of the licenses they grant and supervise.

The Board here is subject to those same limitations. It could not obtain any relief for V.G. It could only do what its authorizing statute, Mo. Rev. Stat. § 334.100 (2000) (*see* Petition at 3), permits: impose censure, reprimand, suspension, or revocation of a physician's license. The Board cannot take action against the plan, nor against Prudential as the plan administrator, regardless of the existence of ERISA, the Board's subpoena authority, or the Missouri Supreme Court's decision.

In asserting that the decision below creates a conflict among the courts, Dr. Fallon fails to recognize the limitations on the Board's role. Instead, he stretches the Board's authority and actions and the Missouri Supreme Court's decision beyond their logical and legal bounds, trying to bring them into conflict with decisions of this and other courts. The fact remains that the decision below merely upholds the Board's authority to investigate whether Dr. Fallon remains qualified for the license it granted him.

2. Dr. Fallon also stretches the precedents of this Court, trying to bring them into conflict with the decision below. He

begins within bounds; he observes, correctly, that "this Court's cases make clear that state laws unquestionably are preempted to the extent they purport to authorize 'alternative enforcement mechanisms' ... to remedial provisions set forth in § 502 of ERISA, 29 U.S.C. § 1132."[3] Petition at 8, quoting *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) ("*Travelers*"). But his errors begin to mount immediately. In defining an "alternative enforcement mechanism," he abandons the facts of the cases on which he relies. In each case he cites, the plaintiff claimed to have been injured by a decision of an ERISA plan, and sought a personal remedy outside the scope of those that ERISA allows. Dr. Fallon does not cite a single case in which this Court addressed the state regulation of licensed professionals.

He begins with *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987). Plaintiff Dedeaux was an ERISA plan participant who suffered a back injury from an employment-related accident. *Id.* at 43. He sued his plan's insurer, Pilot Life, after it terminated disability benefits. *Id.* But Dedeaux did not assert any of the several causes of action available to him under ERISA. *Id.* at 44. Rather, he sued under Mississippi contract and tort law. *Id.* at 43.

Dr. Fallon turns next to *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). Taylor, like Dedeaux, was an

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[3] Section 502(a), states in pertinent part: "A civil action may be brought...(1) by a participant or beneficiary .. (B) to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]" Of course, no "participant or beneficiary" seeks to "recover benefits," "enforce" or "clarify ... rights," or otherwise participate in this case.

ERISA plan participant. *Id.* at 60. He, too, had back injuries that caused a disability. *Id.* at 60-61. And he too, after having been denied benefits by his plan's insurer, sued under state contract and tort theories rather than avail himself of the remedies provided by § 502 of ERISA. *Id.* at 61.

In passing, Dr. Fallon cites *Ingersoll-Rand v. McLendon*, 498 U.S. 133 (1990). There, too, the plaintiff-employee sought "compensatory and punitive damages under various tort and contract theories; he did not assert any cause of action under ERISA." *Id.* at 135.

This Court's holdings that states could not create "alternative enforcement mechanisms" cannot be divorced from the context of the claims in *Pilot Life*, *Taylor*, and *Ingersoll-Rand*, each of them an attempt by a plan participant to obtain personal remedies in the form of tort damages and breach of contract awards. The question was never merely whether a claim was "based on an alleged improper processing of a claim for benefits." *Pilot Life*, 481 U.S. at 48, quoted, Petition at 9-10. In each case it was more specific, *i.e.*, whether "the civil enforcement provisions of ERISA § 502(a) [are] the exclusive vehicle for actions *by ERISA-plan participants and beneficiaries* asserting improper processing of a claim for benefits, and [whether] varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress." 481 U.S. at 50-51 (emphasis added). In *Pilot Life*, *Taylor*, and *Ingersoll-Rand*, this Court ensured that benefits for plan beneficiaries are "subject to a uniform body of benefits law." *Travelers*, 514 U.S. at 655.

In none of those cases did the Court consider state licensing of professionals. The Court never said – and could not logically say – that state laws addressing the competence of medical professionals were part of the "body of benefits law"

covered by ERISA. The Court did not say that the *state*, as opposed to *participant or beneficiary*, could never review an exercise of professional judgment. The Court never suggested that state action to prospectively protect public health was an "alternative enforcement mechanism" precluded by ERISA.

3. Dr. Fallon takes the same tack – stretching precedents beyond their reasonable bounds – when he asserts that the Missouri decision conflicts with the "decisions of several courts of appeals, which have uniformly concluded that state laws that establish 'alternative review mechanisms' for the denial of ERISA benefits are preempted under *Pilot Life*." Petition at 12. By subtly shifting to "alternative review mechanisms," he implies that the "several courts of appeals" have extended the scope of ERISA preemption further than this Court's bar on "alternative enforcement mechanisms." Dr. Fallon reinforces that impression by placing the new, broader phrase in quotation marks. But he provides no citation for his "quote." Indeed, the phrase seems to be his own invention; respondent's searches using electronic databases have failed to find it in any ERISA decision of any U.S. court of appeals.

Indeed, with regard to ERISA preemption in any respect pertinent to this case, the courts of appeals have gone no further than has this Court. Each court of appeals' opinion Dr. Fallon cites decides only what this Court decided in *Pilot Life*, *Taylor*, and *Ingersoll-Rand*: that plan participants and beneficiaries cannot use alternative state mechanisms to obtain remedies that ERISA does not provide.

Dr. Fallon highlights a case brought against him, *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999). Dr. Fallon had determined that Hull, a plan participant, did not need a thallium stress test, notwithstanding a contrary determination by the participant's own physician. Dr. Fallon's medical judgment was wrong; Hull suffered a debilitating heart attack that could have been

prevented had he had the thallium stress test. Because the plan refused coverage based on Dr. Fallon's decision, Hull sued, asserting medical malpractice under state tort law. The court of appeals stated that "although Hull's characterization of his claim sounds of medical malpractice, the essence of his claim rests on the denial of benefits," and, therefore, his suit "falls squarely within the scope of Section 502(a) [and is] completely preempted by ERISA." *Id.* at 943. In so holding, the court was doing nothing more than this Court did in *Pilot Life*, *Taylor*, and *Ingersoll-Rand*.

The other Eighth Circuit cases cited by Dr. Fallon do the same. As Dr. Fallon admits, the claims brought in *Kuhl v. Lincoln National Health Plan*, 99 F.2d 298 (8th Cir. 1993), were "for tortious interference, medical malpractice, and breach of contract." Petition at 14. *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436, 440 (8th Cir. 1997), involved "a state law breach of fiduciary duty claim." Petition at 14. And *Thompson v. Gencar Health Systems, Inc.*, 202 F.3d 1072 (8th Cir. 2000), presented "a malpractice claim brought against a plan administrator." Petition at 15. In these and other cases, the Eighth Circuit may have held "that 'ERISA completely preempts a state law medical malpractice claim.'" Petition at 14, quoting *Thompson*, 202 F.3d at 1073. But it has not extended that holding beyond cases in which a plan beneficiary is attempting to obtain relief outside ERISA's limited remedies.

Dr. Fallon's travels through decisions by other circuit courts of appeals produce equally unhelpful case law. He cites three decisions: *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999), *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), and *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1472 (7th Cir. 1996). All three were actions brought by plan participants or beneficiaries seeking remedies and relief directly related to a denial of benefits. Neither the First, nor the Fifth, nor the Seventh Circuit broadly held, as Dr.

Fallon suggests, that a state can never review a decision that "may entail the exercise of medical judgment" merely because that decision is made in the course of "plan administration." Petition at 18. As in *Hull* and the other Eighth Circuit cases, in each, the other courts of appeals held only that a plan participant or beneficiary cannot rely on state law for remedies that extend beyond ERISA.

4. Every decision that Dr. Fallon suggests is in conflict with the decision of the Missouri Supreme Court, then, holds merely that a plan participant or beneficiary cannot use state law to obtain relief beyond that which ERISA permits. But here, there is no participant or beneficiary plaintiff. There is no request for relief that would flow to or in any way assist a participant or beneficiary. The Board is only trying to protect the public health by determining whether a professional it licensed used his professional judgment in a way that casts doubt on his qualifications to maintain that license. Dr. Fallon's effort falls not within the scope of the precedent he cites, but within a realm that this Court has recently reiterated is not preempted by ERISA.

Even in the ERISA context, there is a "presumption against pre-emption in areas of traditional state regulation." *Egelhoff v. Egelhoff*, 121 S.Ct. 1322, 1330 (2001). The states' "historic police powers" are superseded only if "that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655. This Court's recent declaration in *Egelhoff* merely confirmed what it held in *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 813 (1997), *i.e.*, that when Congress enacted ERISA, it intended that state regulation continue. If Dr. Fallon were to concede that the licensing of professionals, who happen to be employed by an ERISA plan, fell within the presumption in favor of preserving traditional state regulation, his alleged conflict among the courts would evaporate. So without citing precedent nor explaining his logic,

Dr. Fallon asserts that the presumption in favor of continued state regulation "plainly has no application here." Petition at 10.

He does not and cannot argue that any court has held that licensing health professions is outside the scope of traditional state regulation. After all, states have been licensing doctors for nearly 200 years. *See, e.g., Towle v. Marrett*, 2 Maine 22 (1824); *Ex parte Thompson*, 10 N.C. 355 (1824). *See also State v. Hereford*, 13 Mo. 3 (1850). Dr. Fallon instead argues that the Board's investigatory subpoena is not within the traditional domain of state regulation because the act being reviewed, though requiring the exercise of medical judgment, occurred in the course of utilization review. In essence, he suggests that ERISA changed the scope of traditional state regulation — a proposition that finds no support in the cases Dr. Fallon cites nor in the argument he makes. Dr. Fallon then claims that the regulation of professions will become a "back door" through which someone will "attempt to circumvent ERISA's preemption of direct liability claims against plan administrators," Petition at 20-21 (citing professional literature warning doctors of the possibility of licensure review), and that "plan members and others" are filing complaints about physicians employed by ERISA plans at an "alarming rate," Petition at 21 (citing no authority at all). If the day comes when "plan members" obtain relief by going through that "back door," there may be a conflict or other concern that merits this Court's review. But we have not reached that day yet – at least not in Missouri, and not in this case. In fact, Prudential reversed Dr. Fallon's decision regarding V.G. long before the Board began to took at it. *See* Pet. App. at 11a.

5. Finally, Dr. Fallon returns to his efforts to transform this case, a narrow dispute over an investigation into medical judgment, into the proverbial hole that will, if left untended, bring down the managed care dike. But if there is a hole, it is

not untended; the lower courts are already drawing the right line when considering efforts of licensing boards to reach the edges of their authority. That is demonstrated in the only two cases Dr. Fallon cites in which the court actually addressed the ability of licensing boards to study physicians' determinations of medical necessity, *United Healthcare Ins. Co. v. Levy*, 114 F.Supp. 2d 559, 565 (N.D. Tex. 2000), and *Murphy v. Board of Medical Examiners*, 949 P.2d 530, 533 (Az. App. 1997).

Dr. Fallon is right when he asserts that the court in *Levy* held "that ERISA preempts a state medical board's authority to discipline a physician for making improper utilization determinations." Petition at 20. But the Texas board was attempting to review non-medical utilization determinations; the court expressly found that the physician did not "make any finding of medical necessity." 114 F.Supp. 2d at 561 n. 1. Thus it left "the question whether a physician acting as a utilization review agent who exercises medical judgment to determine what is medically necessary for a patient's case ... is subject to the Board's regulatory authority ... for determination on another day in another case." *Id.*

By contrast, the court in *Murphy* was addressing the exercise of medical judgment. The court explained that Dr. Murphy was not just performing utilization review, he was making a "medical decision":

> Dr. Murphy evaluated information provided by both the patient's primary physician and her surgeon. He disagreed with their conclusion . . . . Dr. Murphy substituted his medical judgment for theirs and determined that the surgery was "not medically necessary." There is no other way to characterize Dr. Murphy's decision: it was a "medical decision."

949 P.2d at 536. Dr. Fallon concedes that he made that same kind of decision. Petition at 3.

For licensing agencies to review such medical decisions does not pose a real threat to ERISA's goal of providing employees like V.G. with healthcare benefits. *See Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989). If challenges to such reviews are "recurring" (Petition at 19-20), it will be the result of physicians trying to erase the line defined by cases such as *Levy*, *Murphy* and this one – physicians who want their medical decisions to be immune from professional review, entitling them to retain their licenses even if there are manifest deficiencies in their medical judgment. The possibility that some physicians will follow that course does not merit this Court's review.

CONCLUSION

For the reasons stated above, the Court should deny the writ.

Respectfully submitted,

JEREMIAH W. (JAY) NIXON
Attorney General
JAMES R. LAYTON
State Solicitor
Counsel of Record
RONALD MOLTENI
JAMES O. ERTLE
Assistant Attorneys General
Supreme Court Building
P.O. Box 899
Jefferson City, MO 65102-0899
(573) 751-3321 phone
(573) 751-0774 facsimile

Counsel for Respondent

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IN THE
Supreme Court of the United States

RICHARD FALLON, M.D.,

Petitioner,

v.

STATE BOARD OF REGISTRATION
FOR THE HEALING ARTS,

Respondent.

On Petition For A Writ Of Certiorari To The Supreme Court Of Missouri

REPLY BRIEF FOR PETITIONER

RICHARD J. PAUTLER
LEWIS R. MILLS
THOMPSON COBURN LLP
One Firstar Plaza
St. Louis, MO 63101
(314) 552-6470

MIGUEL A. ESTRADA
Counsel of Record
THOMAS G. HUNGAR
ANDREW S. TULUMELLO
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

Counsel for Petitioner

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REPLY BRIEF FOR PETITIONER

In a string of unanimous decisions that began with *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court has repeatedly held that ERISA preempts *any* state-based attempt to review or correct purportedly erroneous benefits determinations, because those coverage determinations can be reviewed only in accordance with the exclusive provisions of ERISA § 502, 29 U.S.C. 1132. The federal courts of appeals, unsurprisingly, have followed the exclusivity principle set forth in those decisions of this Court. *See* Pet. 12-19 (collecting cases). The Supreme Court of Missouri, however, squarely held in this case that respondent may investigate and discipline Dr. Fallon for his "denial of surgical insurance coverage" to patient V.G., even though it is undisputed that Dr. Fallon was acting solely in his capacity as a utilization review administrator for an ERISA plan. *See* Pet. App. 23a-24a. That departure from the consistent course of federal court decisions clearly warrants this Court's review.

1. Respondent defends the decision below primarily on the ground "that licensing [of] the health professions" is a field "traditionally" left to state law (Br. in Opp. at 10-11), entitling States "to investigate the use of professional judgment in the course of benefits review" with a view toward "revoking or limiting use of the licenses they grant and supervise." *Id.* at 3, 5. According to respondent, were this Court to consider the purportedly medical character of Dr. Fallon's decision, together with "the presumption in favor of preserving traditional state regulation" over "the licensing of professionals," the "alleged conflict among the courts would evaporate." *Id.* at 10.

Respondent cannot avoid *Pilot Life* and its progeny merely by incanting that States "traditionally" have supervised the exercise of "medical judgments," since States likewise "traditionally" engaged in numerous forms of regulation that now are clearly barred by ERISA, including —before *Pilot Life*—punishing certain coverage decisions

directly through the tort of "bad faith" or through punitive damage awards. ERISA's language, and this Court's decision in *Pilot Life,* make it clear that those state efforts are now preempted. Not surprisingly, this Court and the federal courts of appeals have repeatedly rejected the traditional-state-function argument that respondent now advances, giving the lie to respondent's efforts to defend the decision below and to deny the fact that the lower courts are divided. Indeed, as this Court recently noted, "ERISA certainly contemplated the pre-emption of substantial areas of traditional state regulation." *California Div. of Labor Standards v. Dillingham Constr., N.A.*, 519 U.S. 316, 330 (1997). "[T]he traditional or nontraditional nature of the state law," as the Fifth Circuit also has noted, cannot overcome ERISA's language, especially since this Court's cases demonstrate that "the fact that states traditionally have regulated in a particular area has functioned as no impediment to ERISA pre-emption." *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1334 (5th Cir. 1992) (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990)).

Far from supporting respondent's notion that States may isolate and punish medical judgments allegedly made as part of ERISA coverage decisions, the federal courts have been virtually unanimous in rejecting respondent's attempt to attach talismanic significance to the purported "medical" dimension of coverage decisions. As the First Circuit put it, it does *not* matter under ERISA that decisions made by someone in Dr. Fallon's position "may be characterized as medical in nature * * * What matters * * * is that the conduct was indisputably part of the process used to assess a participant's claim for benefits under the plan. As such, ***any state-law-based attack*** on this conduct would amount to an 'alternative enforcement mechanism'" forbidden by ERISA. *Danca v. Private Health Care System, Inc.*, 185 F.3d 1, 5-6 (1st Cir. 1999) (emphasis added); *accord Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1489-90 (7th Cir.

1996); *Corcoran*, 965 F.2d at 1333 (5th Cir. 1992) ("It may be true * * * that Louisiana tort law places duties on persons who make medical judgments within the state * * * But it is equally true that Congress may pre-empt state-law causes of action * * * when it determines that such actions would interfere with a carefully constructed scheme of federal regulation").

2. Respondent also contends that its attempt to discipline Dr. Fallon is *not* an "alternative enforcement mechanism" forbidden by *Pilot Life* and its progeny, because it does not involve any attempt by a plan participant or beneficiary to recover ERISA plan benefits. Br. in Opp. 6. As respondent sees it, "[l]icensure investigations do not currently nor retroactively affect 'utilization review' or the benefits an ERISA plan provides to any participant or beneficiary." *Id.* at 5. Although a conflict "that merits this Court's review" would exist if a participant or beneficiary *instigated* respondent's investigation as a "back door" to influence benefits determinations by the ERISA plan, respondent contends that "we have not reached that day yet." *Id.* at 11.

Respondent's argument would transform the preemption inquiry under ERISA into a free-wheeling, subjective (and quite possibly indeterminate) investigation of the Board's motivations—of how and why ERISA utilization review agents came to be disciplined by the State—and would permit disciplinary action whenever discipline cannot be shown to be directly designed to secure benefits for an identifiable individual. There is no support for that approach in the text of ERISA or in the decisions of this Court. Section 502(a) does not, as respondent suggests (Br. in Opp. 7), preempt only attempts "by a plan participant to obtain" review of an adverse benefits determination or actual attempts to secure ERISA benefits. Section 502 not only specifies the circumstances in which plan participants may bring suit to ensure that ERISA plans are administered properly, but also identifies when employers, plan

fiduciaries, the Secretary of Labor, *and States* may do so. *See* 29 U.S.C. §§ 1132(a)(1)-(9). Those remedial provisions "represent[] a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans" (*Pilot Life*, 481 U.S. at 54), and were plainly intended by Congress to be exclusive of *any* state remedies. *See Ingersoll-Rand*, 498 U.S. at 144.

The comprehensiveness and exclusivity of the remedies set forth in Section 502 preclude other state avenues of relief even when those avenues provide remedies, such as compensatory or punitive damages, that are not available *at all* to *anyone* under ERISA—as *Pilot Life* held. Similarly, this Court in *Ingersoll-Rand* reaffirmed the exclusivity of ERISA's remedies even when the plaintiff never became eligible for benefits because he was discharged to prevent him from attaining eligibility. Indeed, in a statement that anticipated—and rejected—respondent's arguments that its investigation may proceed because it seeks to secure no benefits for ERISA beneficiaries or participants, this Court in *Ingersoll-Rand* emphasized that "it is no answer to a pre-emption argument that a particular plaintiff is not seeking recovery of * * * benefits." *Ingersoll-Rand*, 498 U.S. at 145. Whether initiated by plan participants or others, therefore, *any* state-law attempt to review or correct errors of plan administration falls squarely within ERISA's preemptive scope.[1]

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[1] Where Congress intended to save state laws from preemption, it made its intention express and unequivocal. *See, e.g.*, 29 U.S.C. § 1144(b)(2)(A) (saving state insurance laws); 29 U.S.C. § 1144(b)(4) (saving from preemption "any generally applicable criminal law of a State"). The Board has not claimed that its proceeding against Dr. Fallon is somehow saved from preemption under any of ERISA's "saving" provisions.

Respondent's argument also ignores the fact that ERISA preemption seeks to ensure that plan sponsors and administrators are subject to uniform regulation of employee benefit plans in each of the fifty States without the administrative and financial burden of a hodgepodge of differing and inconsistent state and local regulations. "'[T]he goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government * * * [and to prevent] the potential for conflict in substantive law * * * requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.'" *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-57 (1995) (citation omitted).[2] Because Congress intended ERISA to ensure uniformity in benefits regulation, this Court has "not hesitated to enforce ERISA's pre-emption provision where state law created the prospect that an employer's administrative scheme would be subject to conflicting requirements." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987); *see also Boggs v. Boggs*, 520 U.S. 833, 842 (1997) (ERISA was meant to "secur[e] national uniformity in the administration of employee benefit plans").

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[2] This objective is highlighted in the legislative history of ERISA. *See, e.g.*, 120 CONG. REC. 29,197 (1974) (statement of Rep. Dent) (describing ERISA's "crowning achievement" as the "reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, [ERISA] round[s] out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation"); 120 CONG. REC. 29,933 (1974) (statement of Sen. Williams) ("It should be stressed that with the narrow exceptions specified in [ERISA], the substantive and enforcement provisions * * * are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans").

The decision below creates precisely the type of structure that could subject ERISA plans to conflicting duties in each State of the Union. At the most basic level, and contrary to respondent's assertions, disciplining utilization review agents *for their coverage decisions on behalf of the plan* necessarily pressures those agents (and thus the plan) into making whatever decisions the State disciplinary authorities will find acceptable, irrespective of how the controlling plan documents are interpreted by other utilization review agents in other parts of the country. In this respect, that sort of "discipline" does not differ in essence from punitive damages awards against the plan, which this Court found preempted in *Pilot Life*. Moreover, contrary to respondent's attempt to paint the decision below as narrowly limited to "licensure" requirements, the Supreme Court of Missouri actually concluded that those aspects of plan administration that purportedly embody "medical" judgments are *not* part of plan administration *at all*. *See* Pet. App. at 4a ("the determinations [made by Dr. Fallon] fall outside the scope of plan administration" because "[Dr. Fallon] used medical training and judgment to make a decision about the 'medical necessity' of surgical treatment for a particular patient").[3] Because the decision below is squarely predicated on the notion that Dr. Fallon's conduct is simply not part of "plan administration," the Missouri Supreme Court's ruling necessarily authorizes not only disciplinary actions involving "licensure" laws but also any tort suit that purportedly is predicated on the "medical" component of the utilization review decision.

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[3] *See also* Pet. App. at 6a ("[Although] Prudential made an *administrative* decision when it determined that the plan would not extend to cover [treatment] unless the medical director found it to be 'needed and appropriately provided[,]' * * * Dr. Fallon * * * made a purely *medical* decision when he determined that the procedure was not 'medically necessary'") (emphasis in original).

The rationale employed, and the result reached, by the Supreme Court of Missouri cannot be reconciled with the Eighth Circuit's decision in *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999), which affirmed the dismissal of a state-law medical malpractice claim against Dr. Fallon. *Hull* squarely held that Dr. Fallon's coverage determinations were acts of plan administration reviewable only in accordance with Section 502(a). 188 F.3d at 942. As respondent does here, Hull claimed that his state-law suit against Dr. Fallon was *not* predicated on an act of plan administration but on Dr. Fallon's exercise of flawed medical judgment. *See id.* at 942-43 (asserting claim against Dr. Fallon for medical malpractice). The Eighth Circuit summarily rejected that view, emphasizing that "plan administrators necessarily exercise medical judgment in determining benefits due under the plan" and that any claims that "relate to th[ose] [determinations] fall squarely within the scope of section 502(a)." *Id.* at 943; *see also Kuhl v. Lincoln Nat'l Health Plan, Inc.*, 999 F.2d 298, 303 (8th Cir. 1993) (a plan administrator's "decision not to precertify payment relates directly to [the] administration of benefits").[4]

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[4] Although this Court had occasion to consider issues relating to the administration of ERISA-governed health plans in *Pegram v. Herdrich*, 530 U.S. 211 (2000), it did not rule on any preemption issue. *See* 530 U.S. at 229 n.9 (noting that Court "ha[d] no occasion to discuss" the standards governing a § 502(a) claim for benefits nor "the interaction of such a claim with state law causes of action"). For that reason, every court of appeals that has faced the issue has concluded that *Pegram* did not alter ERISA-preemption doctrine, including the analyses reflected in cases like *Hull*, *Corcoran*, *Jass*, and *Danca*. *See, e.g.*, *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000), *on petition for reh'g*, 220 F.3d 641, 643, *petition for cert. filed sub nom.*, *Montemayor v. Corporate Health Ins., Inc.*, No. 00-665 (Oct. 24, 2000); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 274-75 (3d Cir. 2001).

Hull and the decision below cannot both be correct. If, as the Supreme Court of Missouri held below, ERISA does *not* preempt a state-law challenge to a medical director's coverage determination, then the Eighth Circuit clearly erred in affirming the dismissal of Hull's medical malpractice claim against Dr. Fallon. Just as he did when reviewing V.G.'s claim for benefits, Dr. Fallon determined whether the treatment Hull's physicians had proposed was "medically necessary." Under the rationale of the decision below, Hull presumably would be entitled to seek redress at state law for any harm caused by Dr. Fallon's purportedly improper coverage determination, because Hull's claim would be predicated—*not* on any act of plan administration—but on Dr. Fallon's "medical judgment." Alternatively, if the Eighth Circuit is correct that coverage determinations by a medical director are acts of "plan administration" reviewable only in accordance with Section 502(a), then the Supreme Court of Missouri erred in failing to deem the Board's proceeding against Dr. Fallon preempted. Thus, apart from the fact that this Court's decisions squarely foreclose respondent's arguments on the *merits*, respondent is simply wrong to deny that the decision below squarely conflicts with *Hull* and its progeny—*and* with the decisions of the First, Fifth, and Seventh Circuits in *Danca*, *Corcoran*, and *Jass*. *See* Pet. 16-18. That conflict warrants this Court's immediate attention.

3. Respondent also vastly understates the importance of the question presented. Respondent breezily asserts that allowing state medical boards to investigate and discipline medical directors for making purportedly erroneous coverage determinations will "not pose a real threat to ERISA's goal of providing employees like V.G. with healthcare benefits." Br. in Opp. 13. Quite to the contrary, the decision below could have a devastating effect on the efficient functioning and long-term survival of employer-sponsored health benefit plans. Left unreviewed, the decision below will erect a proverbial sword of Damocles over every medical director, in every managed care organization, who bears responsibility

for making *coverage* determinations under ERISA-governed health plans. Those medical directors inevitably will be pressured to authorize coverage *solely* to avoid professional discipline, even in circumstances in which such a determination would otherwise be inconsistent with their best judgment as to the coverage that plan documents actually authorize.

Moreover, the decision below will subject ERISA plans to a host of conflicting state regulatory directives that make the uniform administration of nationwide employee health plans impossible. Twenty-six States now purport to require medical directors of managed care companies to be licensed physicians in the State in which plan members or the plan reside. *See* Pet. 21-22 & n.7. Left unreviewed, the decision below will invite the medical boards in each of those States to investigate and discipline medical directors and their staffs for making adverse coverage determinations, even where, as in this case, it is undisputed that the medical director did not treat or otherwise recommend care to the plan subscriber. *See* Pet. App. 10a-11a. The burden those disciplinary proceedings would place on plan sponsors and administrators, to say nothing of the medical directors themselves, can hardly be overstated. Indeed, those increased and unpredictable burdens may well cause "employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co.*, 482 U.S. at 11. Immediate review by this Court is necessary to restore the uniformity and predictability in plan administration that ERISA was enacted to ensure.

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For the foregoing reasons and those set forth in the petition, the petition for a writ of certiorari should be granted.

Respectfully submitted.

RICHARD J. PAUTLER
LEWIS R. MILLS
THOMPSON COBURN LLP
One Firstar Plaza
St. Louis, MO 63101
(314) 552-6470

MIGUEL A. ESTRADA
Counsel of Record
THOMAS G. HUNGAR
ANDREW S. TULUMELLO
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

Counsel for Petitioner

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